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ABSTRACT

The cost of clinical negligence litigation is rising year on year. In this era of austerity, a response is critical. In 2011 an NHS Redress Act scheme was introduced in Wales which will align procedures for complaints and restoration. A Scottish No Fault Compensation Review Group recommended in 2011 that tort based liability is abandoned. In England options are limited by virtue of the size and complexity of the NHS. The Government have proposed reform of civil litigation costs which will reduce the legal costs for the NHS by around a third, but the Health Committee issued a report in June 2011 warning that 'preservation of access to justice will be the yardstick by which these proposals will be judged'. In 2003 the Chief Medical Officer (CMO) showed that civil litigation costs reform alone would not adequately balance procedural and substantive justice. A tort based, fast track, low value clinical negligence scheme was proposed. The NHS Redress Act 2006 enabled a scheme to be implemented but England failed to act. Meanwhile reforms of the complaints process, professional and institutional regulation and legal requirements of openness attempted to improve NHS redress. This paper considers firstly whether the NHS reforms combined with the civil litigation costs reforms address the CMOs concerns over clinical negligence litigation. Secondly, I consider two proposed fast track schemes – Lord Justice Jackson favours an NHS Redress Act scheme, and Lord

Young favours an extension of the fast track Road Traffic Act (RTA) Personal Injury scheme implemented in 2010. I compare the two with each other and with the schemes proposed in Wales and Scotland. The English fast track schemes pose advantages over civil litigation cost reform alone, but fall significantly short of the CMO's 2003 recommendations.

INTRODUCTION

Claims against the NHS are rising. In 2009/10, the National Health Service Litigation Authority (NHSLA) received 6,652 claims for clinical negligence - over 500 more than the year before.¹ As we shall see, the Government have published plans to address both the rising number of claims and their cost to defendants, such as the NHS. Why do patients sue? Bismark and Dauer suggest that there are four motivations to medico-legal action:

[R]estoration, including financial compensation or some other intervention to 'make the patient whole again', correction, such as a system change or competence review to protect future patients; communication, which may include an explanation, expression of responsibility, or apology; and sanction, including professional discipline or some other form of punitive action.²

In this paper the term 'redress' refers to the combined goals of restoration, correction, communication and sanction. Aggrieved patients seek redress, which

*With grateful thanks to Professor Ken Oliphant for his comments on an earlier draft. Any remaining errors are my own.

¹ See National Health Service Litigation Authority (NHSLA), *Reports and Accounts 2010* HC 52 (London, 2010).

² M. Bismark, E. Dauer, "Motivations for Medico-Legal Action – Lessons From New Zealand" (2006) 27 *The Journal of Legal Medicine* 55.

goes beyond mere financial compensation.³ The NHS and professional bodies implement complaints procedures and operate systems designed to prevent the repetition of mistakes. A lack of openness amongst the medical profession perpetuated by the clinical negligence litigation process has an adverse impact on the effectiveness of measures designed to communicate and correct. By implementing a 'joined-up' system of redress the success of each individual measure is enhanced.

The Government have proposed reforms which aim to bring about a less litigious society and more affordable justice.⁴ The controversial⁵ proposals focus broadly on civil litigation funding⁶ and administration of justice⁷, but will inevitably effect considerable change on clinical negligence litigation, not least by reducing the costs incumbent on the NHS. It is important, therefore, to assess how far the reforms will impact on the related agenda of improving redress in the NHS. In the first part of the paper, I consider how the Government's funding reform proposals together with other measures designed to improve redress in recent years respond to the criticisms of the clinical negligence system made by the Chief Medical Officer in 2003. I will show that, despite progress in improving various aspects of NHS redress, the clinical negligence litigation system perpetuates injustice for both patients and

³ See A.-M. Farrell, S. Devaney and A. Dar, *Interim Report to the No Fault Compensation Review Group, Scotland*, "Literature review – No Fault Compensation Schemes for Medical Injury: A Review" (28 January 2010).

⁴ Ministry of Justice, *Solving Disputes in the County Courts: Creating a Quicker, Simpler and More Proportionate System* Consultation Paper CP6/2011, p. 6.

⁵ Working Group on Civil Litigation Costs (chaired by Ken Oliphant), *On a Slippery Slope - A Response to the Jackson Report* (2011), accessible at <http://ectil.org/oliphant/slippery-slope/> and discussed below.

⁶ Ministry of Justice, *Proposals for Reform of Civil Litigation Funding and Costs in England and Wales: Implementation of Lord Justice Jackson's Proposals* CP 13/10, November 2010; Ministry of Justice, *Reforming Civil Litigation Funding and Costs in England and Wales – Implementation of Lord Justice Jackson's Recommendations: The Government's Response* Cm 8041, March 2011; Ministry of Justice, *Legal Aid Reform in England and Wales; the Government Response*, Cm 8072, June 2011.

⁷ *Solving Disputes in the County Courts*, see note 4 above.

healthcare professionals. Furthermore, it impacts adversely on other means of achieving redress, such as complaints procedures.

In the second part of the paper I consider two proposals for fast track low value clinical negligence schemes. Lord Justice Jackson proposed that the abandoned NHS Redress Act 2006 is resurrected;⁸ Lord Young proposed that the Road Traffic Act fast track scheme is extended to clinical negligence claims.⁹ Both offer considerable advantages over civil cost reform alone. Neither option addresses or ‘joins up’ the various aspects of redress to the extent that is likely to be achieved in Wales and Scotland, or satisfies the requirements for ‘just redress’ set down by the CMO.

Because I concentrate on the linkage between the various elements of redress, I cover an ambitiously large area for a short article. I will therefore pick out only the most important aspects of the recent reforms and proposals.

A. IS NHS REDRESS FIT FOR PURPOSE?

1. MAKING AMENDS

In *Making Amends*,¹⁰ Sir Liam Donaldson, the Chief Medical Officer addressed the various aims of redress in his proposals to reform clinical negligence in the NHS. Sir Donaldson complained that:

– it is complex;

⁸ The Right Honourable Lord Justice Jackson, *Review of Civil Litigation Costs, Final Report*, (London: The Stationery Office, 2010), chapter 23, paras. 7 and 8.

⁹ HM Government, Lord Young, *Common Sense, Common Safety* (2010), 23.

¹⁰ CMO, *Making Amends: A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (London: Department of Health, 2003).

- it is unfair – apparently similar cases may reach different outcomes;
- it is slow ... ;
- it is costly in legal fees; diversion of clinical staff time from clinical care; staff morale; and public confidence;
- patients are dissatisfied with the lack of explanations and apologies or reassurance that action has been taken to prevent repetition;
- it encourages defensiveness and secrecy and stands in the way of learning and improvement in the health service.¹¹

The CMO in *Making Amends* recommended a fast track clinical negligence system which should address not only restoration, but also correction and communication.

The report states:

[A]n independent evaluation of a small claims pilot supported by the Department of Health and NHSLA found that even patients who receive compensation often remain dissatisfied if they do not also receive the explanations or apologies they seek or reassurance about the action taken to prevent repetition.¹²

The NHS Redress Act 2006 was enacted. As we shall see, it fell short of the CMO's recommendations.¹³ In England, secondary legislation to implement the scheme was delayed, ostensibly to allow new complaints procedures to embed. In 2009 the House of Commons Select Committee called for immediate implementation, claiming the failure to do so caused protracted delays for litigants, increased litigation costs to

¹¹ *Ibid.*, p. 13.

¹² *Ibid.*, at 7.5 – 7.6.

¹³ A.-M. Farrell, S. Devaney, "Making Amends or Making Things Worse? Clinical Negligence Reform and Patient Redress in England" (2007) 27(4) *Legal Studies* 630.

the NHS, encouraged defensiveness by NHS organisations, and hindered a safety culture.¹⁴ Measures addressing other aspects of the redress system made progress. The Government have not published plans to resurrect the NHS Redress scheme, but following the advice of Lord Young, instead launched a consultation proposing the extension of the Road Traffic Act scheme to cover low value clinical negligence claims.¹⁵

2. A (PERCEPTION OF) COMPENSATION CULTURE?

Since *Making Amends*, claims and costs have risen further still.¹⁶ In 2006 the Constitutional Affairs Committee investigated whether the rise in litigation was a result of a 'compensation culture'.¹⁷ They found little evidence that it was. A rise in claims does not necessarily correlate with a culture of compensation.¹⁸ However the Committee concluded that 'there is ample evidence that risk aversion is becoming an insidious problem which the Government and the Health and Safety Executive must attempt to address'.¹⁹ Today, the Government sends out mixed messages,²⁰ vacillating between claims that we are in the midst of a compensation culture²¹ and

¹⁴ *House of Commons Select Committee Report on Patient Safety*, (2009) section 4.

¹⁵ *Solving Disputes in the County Courts*, see note 4 above.

¹⁶ NHSLA, *Reports and Accounts 2010* HC 52 (London, 2010). '£787 million was paid in connection with clinical negligence claims during 2009/10, up from £769 million in 2008/09.' <http://www.nhsla.com/home.htm>.

¹⁷ Constitutional Affairs Committee, *Compensation Culture: Third Report of Session 2005-06* (London: The Stationary Office, 2006), HC 754-I, para. 111.

¹⁸ K. Oliphant, R. Lewis, A. Morris, "Tort Personal Injury Claims Statistics: Is There A Compensation Culture In The United Kingdom?" (2006) 14 *Torts Law Journal* 158.

¹⁹ *Ibid.*

²⁰ A. Morris, "'Common Sense Common Safety': The Compensation Culture Perspective" (2011) 27(2) *Journal of Professional Negligence* 82 at p. 83.

²¹ *Common Sense, Common Safety*, see note 9 above, Foreword: David Cameron: 'A damaging compensation culture has arisen ...'; Lord Young: 'I believe that a 'compensation culture' driven by litigation is at the heart of the problems that so beset health and safety today.' See also *Solving Disputes in the County Courts* see note 4 above, at p. 4: 'A newer burden on the system is the move towards a compensation culture, driven by litigation'; and p. 6 recommending proposals to 'challenge one of the roots of the developing compensation culture'.

the more reserved claim that there is a *perception* of a compensation culture.²² The Compensation Act 2006 attempted to reduce the litigious nature of society, not by changing the law of negligence,²³ but by regulating the claims management industry. In 2010 Lord Young recommended further legislation to consolidate health and safety legislation²⁴ and in 2011 the package of proposals to reform administration and justice and civil funding costs aim (in part) to produce 'a shift that should start to challenge one of the roots of the developing compensation culture'.²⁵

The CMO emphasised both the financial implications of clinical negligence litigation and its damaging effects on both claimants (whose claims were dealt with too slowly and who frequently did not get the information or the form of redress they sought) and doctors (for whom litigation was stressful and damaging). Recession and financial crisis perpetuate the perception that the pendulum has swung too far in the direction of substantive justice at the expense of procedural justice. Cost cutting has become the primary goal. The 'perception' of a compensation culture makes this more palatable. It emphasises the stifling effect a litigious society has on business and the fact that scarce NHS resources are diverted from patient care into the pockets of vexatious claimants and greedy solicitors. The difficulty is that whilst cutting the costs of clinical negligence litigation is a worthy goal, ignoring patient's interests will result in damaged confidence in NHS redress and will ultimately necessitate further reform.

²² *Common Sense, Common Safety*, see note 9 above, Foreword and at p. 11: the report refers to the 'belief that there is a nationwide compensation culture'; p. 19: the report recognises that 'The problem of the compensation culture prevalent in society today is, however, one of perception rather than reality.'

²³ *Uren v. Corporate Leisure Ltd* [2010] EWHC 46 (QB), per Field J. at [19]. Note the Compensation Act 2006 (Amendment) Bill 2009-10 Bill 58 (to amend the s. 1 of the Compensation Act 2006 so as to apply a presumption that defendants engaged in a desirable activity satisfy the standard of care) was dropped after the first reading in February 2010.

²⁴ *Common Sense, Common Safety*, see note 9 above.

²⁵ *Solving Disputes in the County Courts*, see note 4 above, at p. 6.

3. HOW FAR HAVE WE COME?²⁶

We have seen that the CMO sought to address the problems inherent in clinical negligence litigation via a new tort based, fast track scheme. Since 2003, however, there have been a number of reforms designed to impact on NHS redress more generally. In this section I examine each of the CMO's recommendations in order to assess how far the previous Administration's NHS reforms coupled with the Government's reform proposals relating to the NHS and to civil litigation cost reform address his requirements.

–‘Making Amends’ recommended that: ‘the system of compensation is affordable and reasonably predictable in the way it operates’. ... Any financial compensation is provided fairly and efficiently ... Remedial treatment, care and rehabilitation are available to redress harm and injuries arising from healthcare²⁷

The most recent statistics show a record number of claims and associated costs. The NHS Litigation Authority (NHSLA) reported in 2009/10 a 10 per cent increase in claims over 2008/9, which itself was an 11 per cent increase over 2007/8.²⁸ Legal costs are high.²⁹ Conditional Fee Arrangements were introduced by an amendment to the Courts and Legal Services Act in 1995. They resulted in high claimant costs which, in the NHSLA's view, were frequently disproportionate to the damages paid

²⁶ These measures are analysed more fully in M. Brazier and E. Cave, *Medicine, Patients and the Law* 5th ed. (Penguin: London, 2011 (forthcoming)), chapter 9.

²⁷ *Making Amends*, see note 10 above, p. 13.

²⁸ NHSLA, *Reports and Accounts 2010* HC 52 (London, 2010), p. 13

²⁹ NHSLA (website), *Key Facts About Our Work*, ‘£769 million was paid in connection with clinical negligence claims during 2008/09, up from £633 million in 2007/08’ accessible at <http://www.nhsla.com/home.htm>. And see ‘Cost Warning over NHS Claims’ (2010) 4(1) *Law Society Gazette* 29.

out. These result in the NHSLA paying out considerably more on claimant costs than it does to fund defences.³⁰

The Government are keen to address rising costs, a problem which is particularly acute in medical litigation. An obvious solution is to limit the liability of the NHS,³¹ but can costs be rebalanced, without damaging access to justice? The Government, in Part 1 of the Legal Aid, Sentencing and Punishment of Offenders Bill 2011, are considering eliminating Legal Aid in a range of cases, including most clinical negligence cases,³² and replacing it with no-win-no-fee agreements.³³ The Government seek to avoid contravention of Article 6 of the European Convention of Human Rights³⁴ by setting up an 'exceptional funding scheme', promising that:

[T]here may be particularly complex cases where [...] it may be difficult to find a CFA, but the exceptional funding scheme for out of scope cases will ensure that individual cases of this type continue to receive legal aid.³⁵

Part 2 of the Legal Aid, Sentencing and Punishment of Offenders Bill takes forward Lord Justice Jackson's proposals in his Civil Litigation Costs Review.³⁶ The Bill is an

³⁰ NHSLA *Reports and Accounts 2010* HC 52 (London, 2010), p 14: 'The costs claimed by claimant lawyers continue to be significantly higher than those incurred on our behalf by our panel defence solicitors. This remains a very significant concern for us and attracted significant coverage in the press during the year. The availability of Conditional Fee Agreements (CFAs) and the increase in their use by claimants in clinical claims has meant that claimants' costs are often significantly disproportionate to the amount of damages paid, particularly in low-value claims.'

³¹ For example Part II of the Australian New South Wales Civil Liability Act 2002 reduced the number of and value of personal injury claims. For critique see T.A. Faunce, "Reducing Injustice From Recent Legislation Subsidising Insurance and Restricting Civil Liability" (2010) 15(5) *Journal of Law and Medicine* 729; Also Law Council of Australia, *Tort Law Reform: Bringing Balance to Personal Injury Law* (website) accessible at http://www.lawcouncil.asn.au/programs/national-policy/tort-law-reform/tort-law-reform_home.cfm.

³² Ministry of Justice, *Proposals for the Reform of Legal Aid in England and Wales*, Consultation Cm 7967 (2010); Ministry of Justice, *Legal Aid Reform in England and Wales; the Government Response*, Cm 8072, June 2011.

³³ N. Hanman, "Legal Aid Cuts Put Access to Justice at Risk, Say Lawyers" *The Guardian* 17 August 2010.

³⁴ *Bobrowski v Poland* [2008] ECHR 64916/01; *Bakan v Turkey* 56547/00 [2002] ECHR 604.

³⁵ Ministry of Justice, *Legal Aid Reform in England and Wales; the Government Response*, Cm 8072, June 2011, para. 37.

enabling Bill and therefore lacks detail. The Association of Personal Injury Lawyers say of it:

Cutting legal aid for medical injuries at the same time as restricting 'no win, no fee' is a savage blow for patients whose lives may have been shattered by their injuries. ... The drive to cut costs by forcing injured people to give up part of their compensation to pay legal fees is unfair, unjust and unwarranted. ... People don't choose to be injured, but when negligence happens, the guilty party – the losing defendant - must surely be held fully to account.³⁷

There are two strands to Lord Justice Jackson's proposals, which have a far wider remit than clinical negligence. One is to assert more effective control over case and cost management. The aim would be to ensure that costs are proportional, even if this means that some cases do not go to trial. Alternative Dispute Resolution (ADR), particularly mediation, will play a more prominent role.³⁸ Too many cases settle at a late stage, driving up costs. Lord Justice Jackson did not recommend that mediation is compulsory on the basis that it is not required in 95 per cent of cases personal injury cases.³⁹ In the remaining 5 per cent:

The outcomes which claimants typically seek in clinical negligence cases are: an apology; an explanation as to what happened; reassurance of reform ...;

³⁶ Lord Justice Jackson, see note 8 above. See Ministry of Justice, *Proposals for Reform of Civil Litigation Funding and Costs in England and Wales* CP 13/10, closed 14 February 2011.

³⁷ Association of Personal Injury Lawyers (APIL), Press Statement: *Legal Aid, Sentencing and Punishment of Offenders Bill - Response from Association of Personal Injury Lawyers* (June 2011).

³⁸ Lord Justice Jackson, see note 8 above, chapter 36. And see A. Brady, "Jackson Endorses the benefits of Mediation in the Legal Process in England and Wales" (2010) 76(2) *Arbitration* 251.

³⁹ Lord Justice Jackson, *ibid*, chapter 36, para. 2.11.

and (occasionally) revenge in the form of regulatory intervention. ... These objectives are best achieved by mediation.⁴⁰

The second, in what might be seen as a step back to pre-1999 law, is to make claimants under a CFA liable to pay their lawyer's success fee out of their damages, rather than being able to recover them (as at present) from the defendant.⁴¹ The level of general damages would be increased by 10 per cent to assist claimants, though it is not clear that this would always cover their costs, especially as insurance premiums are likely to rise. In February 2011 a report by an independent working group chaired by Professor Ken Oliphant condemned the proposals.⁴² The report argues that the evidential base relied on by Lord Justice Jackson is inadequate, leading to a misleading and biased picture. It labels the proposals:

... inconsistent with a fundamental principle of civil justice – the principle of full compensation for wrongful injury – because they entail the ‘raiding’ of damages recovered by successful claimants to pay for their legal costs. They would be the beginning of a slippery slope towards ever greater inroads into the compensation to which injured persons are legally entitled.⁴³

The Government announced in June 2011 that where claimants must fund expert reports, the ATE insurance premium will remain recoverable.⁴⁴ The Health

⁴⁰ *Ibid.*, chapter 36, para. 2.14.

⁴¹ See criticism of the success fee regime in *MGN Ltd v the United Kingdom* [2011] ECHR 39401/04 and *Pankhurst v White and MIB* [2010] EWCA Civ 1445 where Jackson LJ said: “I regret to say that I regard the arrangements made by the claimant’s solicitors in this case as grotesque. In addition to their base costs (ie their proper costs of conducting the litigation) they are extracting from the Motor Insurers’ Bureau a ‘success fee’ of some £100,000 for running a risk which simply did not exist.”

⁴² Working Group on Civil Litigation Costs (chaired by Ken Oliphant), *On a Slippery Slope - A Response to the Jackson Report* (2011), accessible at <http://ectil.org/oliphant/slippery-slope/>. See also APIL Press Statement: *Justice Bill a Savage Blow for Injured People*, 29 June 2011.

⁴³ *Ibid.*, p i. See also R. Rothwell, ‘APIL Chief Urges Government to Give Road Traffic Act Portal a Change’ *Law Society Gazette* 24 February 2011, arguing that changes post-Jackson LJ’s report (specifically the RTA Portal introduced in 2010) ‘addressed Jackson’s concerns in 75% of all personal injury cases ‘at a stroke’, and would provide a ‘streamlined, fast-track’ process’.

⁴⁴ *Implementation of Lord Justice Jackson’s Recommendations: The Government’s Response*, see n 5 above, para. 24.

Committee remains concerned. The retention of ATE insurance for clinical negligence claims combined with the end of recoverability of success fees from the defendant might reduce the compensation package for the most severely injured claimants.⁴⁵

The Committee considers that preservation of access to justice will be the yardstick by which these proposals will be judged by the public and that the Government must take care to gauge its proposals against this measure.⁴⁶

Nevertheless, the Ministry of Justice published a response to the consultation in March 2011⁴⁷ concluding:

Taken as a whole, the package of measures will restore a much needed sense of proportion and fairness to the current regime – not by denying access to justice, but by restoring fair balance to the system. Defendants should benefit from more proportionate total legal expenses, with legal costs for the NHS falling by around a third.⁴⁸

In conclusion, the Government are acting on the CMO's concern that clinical negligence litigation is neither affordable nor predictable, but, as we shall see, a number of measures proposed by the CMO to ensure that the system *makes amends* to claimants have not been and are not being taken forward. Consequently, the proposed civil cost reforms will save the NHS money but the adverse impact on access to justice may be significant.

⁴⁵ Health Committee *Sixth Report - Complaints and Litigation* (June 2011), para. 179.

⁴⁶ *Ibid*, para. 180.

⁴⁷ *Implementation of Lord Justice Jackson's Recommendations: The Government's Response*, see n 5 above.

⁴⁸ *Ibid*, para. 33.

– ‘*Making Amends*’ recommended that: ‘risks of care are reduced and patient safety improves because medical errors and near misses are readily reported, successfully analysed and effective corrective action takes place and is sustained’;⁴⁹

Evidence suggests that defensiveness amongst the medical profession is a persistent problem,⁵⁰ though the associated costs are difficult to quantify.⁵¹ The ‘duty of candour’ is limited.⁵² The case of Colin Freeman⁵³ demonstrates the problem well. Freeman suffered a stroke which might have been avoided had hospital staff made the correct diagnosis. When his wife complained, the hospital responded cautiously, refusing to admit any error. Investigation by a law firm led to a different conclusion and the Trust admitted liability. Sankey labels the Trust’s statement a ‘misleading denial’ and calls for the NHS to tackle its ‘culture of denial’, and assert a legal duty of candour to patients.⁵⁴ The CMO recommended such a duty in *Making Amends*,⁵⁵ and the House of Commons called for the duty to be reconsidered in 2009.⁵⁶

The Department of Health has responded cautiously and disjointedly. It promised a culture of openness in *High Quality Care for All*.⁵⁷ Section 2 of the

⁴⁹ *Making Amends*, see note 10 above, p. 13.

⁵⁰ Department of Health, *Safety First: A Report for Patients, Clinicians and Healthcare Managers* (London, 2006); House of Commons Health Committee, *Patient Safety – Sixth Report of Session 2008-2009*. (London: The Stationery Office, 2009) Volumes 1 and 2.

⁵¹ J. Taylor “NHS Compensation Culture: Do Patients Justice’ (2008) Nov 20 *Health Services Journal* 20.

⁵² See *Lee v South West Thames Regional Health Authority* [1985] 1 W.L.R. 845, CA “I personally think that in professional negligence cases, and in particular in medical negligence cases, there is a duty of candour resting on the professional man.” Per Donaldson MR. Also Treasury Solicitor’s Department, *Guidance on Discharging the Duty of Candour and Disclosure in Judicial Review Proceedings* (January 2010).

⁵³ Discussed by P. Sankey, “Comment: A Patient’s Right to Know” (2010) 18 Mar *Law Society Gazette*, 10.

⁵⁴ See also AvMA, *Legal Duty of Candour* (website) accessible at: http://www.avma.org.uk/pages/legal_duty_of_candour_-_robbies_law.html.

⁵⁵ *Making Amends* see note 10 above, pp. 18 and 125.

⁵⁶ House of Commons, *Health Committee: Sixth Report* (2009), para. 91.

⁵⁷ Department of Health, *High Quality Care for All* Cm 7432 (2008), ch. 5, paras. 21-25.

Compensation Act 2006 reassures healthcare professionals (and others) that: 'An apology, offer of treatment or other redress shall not of itself amount to an omission of negligence or breach of statutory duty.' According to the National Patient Safety Agency: 'Saying sorry is not an admission of liability and is the right thing to do. ... Patients have a right to expect openness in their healthcare';⁵⁸ a stance enforced by the Care Quality Commission,⁵⁹ the NHS Litigation Authority,⁶⁰ and the General Medical Council (GMC)⁶¹.⁶² In April 2010 a statutory duty to report incidents was introduced.⁶³ The NPSA will pass on details of incidents to the Care Quality Commission which can impose fines and registration penalties if the guidelines are not strictly followed.

A more comprehensive approach was promised in the Department of Health's White Paper *Liberating the NHS*, where the Government undertook to 'require hospitals to be open about mistakes and always tell patients if something has gone wrong'.⁶⁴ However, there is no logical reason to restrict the duty to hospitals. Primary carers too might be required to be candid. Furthermore, it is unclear how the Government intend to achieve this goal. Early day motions in 2010⁶⁵ proposed that the duty be put on a statutory footing, but the Government are keen to avoid new legislation and the resulting bureaucracy.⁶⁶ Parliamentary Under-Secretary of State

⁵⁸ NPSA, *Being Open: Communicating Patient Safety Incidents with Patients, Their Families and Carers* NPSA/2009/PSA003, (London: DH, 2009) p 6.

⁵⁹ Care Quality Commission, *A Quality Service, A Quality Experience* (London: CQC, 2009).

⁶⁰ National Health Service Litigation Authority, *Apologies and Explanations: Letter to Chief Executives and Finance Directors* (London, 2009).

⁶¹ GMC, *Good Clinical Practice* (2006), para. 30.

⁶² See J. Wright, G. Opperman, 'The Disclosure of Medical Errors: A Catalyst for Litigation or the Way Forward for Better Patient Management?' (2008) 14 *Clinical Risk* 193.

⁶³ Care Quality Commission (Registration) Regulations 2009, SI 2009/3112, Regulation 18.

⁶⁴ White Paper, *Equity and Excellence: Liberating the NHS* Cm 7881 (2010), p. 3. For critique see V. Shekar, M. Singh, K. Shekar, P. Brennan, "Clinical Negligence and Duty of Candour" *British Journal of Oral and Maxillofacial Surgery* (2010) advance on-line publication.

⁶⁵ T. Brake, *Campaign for a Statutory Duty of Candour in Healthcare* EDM 1163, 23 March 2010; T. Brake *Duty of Candour in Healthcare* EDM 486, 13 July 2010.

⁶⁶ D. West, "Lansley Against Legal Duty of Candour" *Nursing Times* 11 June 2010.

for Health, Anne Milton, outlined two additional options.⁶⁷ The first is to utilise existing Care Quality Commission regulations to require healthcare organisations to show that they have been open. But this might prove difficult to enforce in court. The second option is to require openness through new NHS contractual and commissioning processes. To this end, the Government recently promised to introduce a contractual duty of candour.⁶⁸ It seems that if the Government are to make good their promise, the duty of candour is likely to be imposed incrementally, and will lack the emphasis and culture change of a statutory duty. The Health Committee argues that the proposals do not go far enough: they call for an additional contractual duty between providers and commissioners, and a duty from providers to patients as part of the terms for authorisation from Monitor or licence from the Care Quality Commission.⁶⁹

Requiring openness is only part of the solution. In addition it is necessary to create an environment whereby doctors are willing to admit their errors or mistakes, and to report those of others, whilst maintaining individual and institutional sanctions by which they can be held to account.⁷⁰ The current clinical negligence system acts as a disincentive to openness. The CMO recommended that a statutory duty of candour be accompanied by an exemption from disciplinary action, at least where no crime has been committed and it remains safe for the doctor to practise.⁷¹ In addition, documents identifying adverse events would be protected from disclosure

⁶⁷ HC Deb 1 Dec 2010 : Column 285WH - Column 291WH.

⁶⁸ Department of Health, *Government Response to the NHS Future Forum report*, Cm 8113, June 2011: 'We heard through the listening exercise the suggestion that we could strengthen transparency of organisations and increase patient confidence by introducing a 'duty of candour': a new contractual requirement on providers to be open and transparent in admitting mistakes. We agree. This will be enacted through contractual mechanisms and therefore does not require amendments to the Bill. We will set out more details about this shortly.'

⁶⁹ Health Committee *Sixth Report - Complaints and Litigation* (June 2011), paras. 80-81.

⁷⁰ For an alternative system see P. Vines, "Apologies and Civil Liability in the UK: A View from Elsewhere" (2008) 12(2) *Edinburgh Law Review* 200.

⁷¹ *Making Amends* see note 10 above, p. 18 and recommendation 12, p. 125.

in court, as is the case in parts of Canada, Australia and the US.⁷² This does not seem to form part of the Government's plans, yet without it the incentive for openness and honesty remains limited.

– *'Making Amends' recommended that: 'payments of compensation act as financial incentives on healthcare organisations and their staff to improve quality and patient safety'*⁷³;

Somewhat predictably, the Government claim that the previous Administration took the wrong approach to improving quality and patient safety in the NHS. It increased the regulation of the healthcare profession⁷⁴ with a raft of process-driven targets. The Government vow to change all that⁷⁵ – to free the NHS from top-down bureaucracy. The Public Bodies Bill 2010 aims to reduce the number of arms-length bodies; the much maligned Health and Social Care Bill 2011 proposes the most far reaching reforms of the NHS yet – creating groups of GPs, Commissioning Consortia, who will commission the majority of services. New registration and licensing measures have already been introduced.⁷⁶ An independent healthcare regulator, the Care Quality Commission (CQC), produces outcome-based guidance,⁷⁷ against which providers demonstrate their compliance. Failure can result in the imposition of a range of sanctions, including a fine of up to £50,000.⁷⁸ The CQC publish on their website the

⁷² *Making Amends, ibid*, recommendation 13, p. 126.

⁷³ *Making Amends*, see note 10 above, p. 13.

⁷⁴ A. Davies, "Don't Trust Me, I'm a Doctor: Medical Regulation and the 1999 NHS Reforms" (2000) 20 *Oxford Journal of Legal Studies* 437.

⁷⁵ White Paper, *Equity and Excellence: Liberating the NHS* Cm 7881 (2010).

⁷⁶ The Health and Social Care Act 2008 (Registration of Regulated Activities) Regulations 2009, SI 2009/660.

⁷⁷ Care Quality Commission Guidance about Compliance: Essential Standards of Quality and Safety, (Marcy 2010).

⁷⁸ See the Health and Social Care Act 2008, ss. 17(1), 18(2) and 31.

registration status of Trusts, which are required to publish an annual Quality Account.⁷⁹ The aim is to improve public accountability.

There is much work to be done working out how to choose, define and measure outcomes,⁸⁰ but they will include clinical outcomes, quality of life and crucially, patient perceptions of healthcare. To put it crudely, if providers do not satisfy patients, they are less likely to be chosen to provide care by the Commissioning Consortia, and will suffer financially as a result. There is therefore a financial incentive to improve quality. There is debate as to how statistics on compensation claims and complaints might be used. On one hand they represent patient dissatisfaction which should count against the provider. On the other hand, they might represent a healthy approach to information disclosure and a well signposted complaints process. Care will need to be taken when publishing complaints statistics to qualify the type of complaints and ensure that providers who obstruct the path to restoration with a lack of openness or poor attitudes suffer the consequences.

Professional regulation plays its part. Reforms (and reform proposals) of the GMC (introducing licenses to practice⁸¹ and, by 2012 revalidation⁸² and reforming fitness to practice proceedings⁸³) have been well received.⁸⁴ The fact that revalidation has been streamlined and watered down⁸⁵ is not necessarily to be

⁷⁹ The National Health Service (Quality Accounts) Regulations 2010, SI 2010/279.

⁸⁰ A. Lansley, Secretary of State for Health, in *Transparency in Outcomes – A Framework for the NHS* (2010).

⁸¹ The General Medical Council (Licence to Practise) Regulations Order of Council 2009, SI 2009/2739.

⁸² GMC, CMOs and Medical Director of NHS, *Revalidation: A Statement of Intent* (2010).

⁸³ The General Medical Council (Fitness to Practise) (Amendment in Relation to Standard of Proof) Rules Order of Council 2008, SI 2008/1256; The General Medical Council (Fitness to Practise) (Amendment) Rules Order of Council 2009, SI 2009/1913.

⁸⁴ CHRE, *Fitness to Practise Audit Report* (2010), p. 27, which labels the GMC's fitness to practise procedures robust and effective.

⁸⁵ Ministerial Statement, HC Deb, 26 July 2010 c65-6WS.

lamented given the positive effect this might have on the confidence of doctors.

Over-regulation and harsh sanctions are likely to leave doctors resentful and heighten secrecy when things go wrong.

– *‘Making Amends’ recommended that: ‘different entry points to expressing complaints and concerns about standards of care are well co-ordinated and well understood by the public and healthcare professionals’.*⁸⁶

Not only does an effective complaints process enable the NHS to learn from its mistakes, it also offers an alternative to litigation.⁸⁷ The NHS complaints procedure⁸⁸ provides redress in the forms of communication, correction and potentially, sanction. Despite reforms in 1996⁸⁹ and 2004,⁹⁰ patients still found the complaints process inflexible, the system complex and slow and the healthcare professionals defensive and closed.⁹¹ Reforms in 2009⁹² simplify the law and align complaints procedures in relation to local authority social services and the NHS. ‘Responsible bodies’ are required to publicise their complaints arrangements⁹³ and to disclose information about complaints in annual reports.⁹⁴ The NHS Constitution

⁸⁶ *Making Amends*, see note 10 above, p. 13.

⁸⁷ S. Kraman, G. Hamm “Risk Management: Extreme Honesty May be the Best Policy” (1999) 131(12) *Annals of Internal Medicine* 963. *Making Amends*, see note 10 above chapter 2, para. 27.

⁸⁸ See T. Powell, *NHS Complaints Procedures in England* (15 October 2010) accessible at <http://www.parliament.uk/briefingpapers/commons/lib/research/briefings/snsp-05401.pdf>.

⁸⁹ NHSE, *Complaints – Listening – Acting – improving: Guidance on Implementation of the NHS Complaints Procedures* (London: DH, 1996).

⁹⁰ Department of Health, *NHS Complaints Reform- Making Things Right*, (London, 2003); NHS (Complaints) Regulations 2004, SI 2004/1768 as amended in NHS (Complaints) Amendment Regulations 2006, SI 2006/2084.

⁹¹ Department of Health, *Making Experiences Count: A New Approach to Responding to Complaints*, (London, 2007); National Audit Office, *Feeding Back? Learning From Complaints Handling in Health and Social Care*, (London: The Stationery Office, 2008); Healthcare Commission, *Spotlight on Complaints: A Report on Second-stage Complaints About the NHS in England*, (London: The Stationery Office, 2009).

⁹² Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, SI 2009/309, as amended by The Local Authority Social Services and National Health Service Complaints (England) (Amendment) Regulations 2009, SI 2009/1768.

⁹³ *Ibid*, Regulation 16.

⁹⁴ *Ibid*, Regulation 18.

reiterates the right to complain and pledges (in other words, promises to prioritise and develop in future):

- when mistakes happen, to acknowledge them, apologise, explain what went wrong and put things right quickly and effectively; and
- to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services.⁹⁵

The reforms aim to ensure that complaints are acted upon and dealt with swiftly, but the NHS Ombudsman reported in 2010 that the process is still poorly signposted and mistakes are being repeated.⁹⁶ Some NHS staff adopt an inappropriate attitude to complainants. Explanations and apologies, which she reminds us are ‘simple to deliver and costing nothing’,⁹⁷ are too infrequently offered.⁹⁸ The failures of the regulatory system to react quickly and effectively to appalling standards of care at Mid-Staffordshire⁹⁹ have led to further questions about the adequacy of the complaints process. At a House of Commons Health Committee investigation¹⁰⁰ the Health Service Ombudsman called for the Government to allow the 2009 reforms to embed before imposing additional changes on the system. The reforms will improve the sharing of information between complaints handlers (and HealthWatch in future) and regulators such as the CQC and Monitor. This in turn will enable systemic

⁹⁵ Provided for in Health Act 2009, Part 1, the NHS Constitution came into force in January 2010. Department of Health, *The NHS Constitution for England*, (London: The Stationary Office, 2009).

⁹⁶ Parliamentary and Health Services Ombudsman *Listening and Learning: The Ombudsman's View of Complaint Handling by the NHS in England 2009-10* (2010), 4; and see Parliamentary and Health Services Ombudsman *Care and Compassion- Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People* (15 February 2011)

⁹⁷ *Listening and Learning*, p. 4.

⁹⁸ *Listening and Learning*, p. 14.

⁹⁹ *Final Report of The Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust* (2010). Accessible at <http://www.midstaffsinquiry.com/pressrelease.html>.

¹⁰⁰ *Complaints and Litigation - Oral Evidence* 15 February 2011 accessible at <http://www.parliamentlive.tv/Main/Player.aspx?meetingId=7688i>.

investigations and change. The Health Committee agreed that the two stage process has strong potential¹⁰¹ but recommended that 'clear national standards for complaints handling'¹⁰² are introduced; that 'one organisation [HealthWatch England] should be responsible for maintaining an overview of complaints handling in the NHS';¹⁰³ and that providers are more transparent and accountable to their commissioners about the number of complaints they receive and how they are handled.¹⁰⁴

The 2009 reforms offer swifter resolution of complaints but this comes at a price. The second of what was previously a three-stage process has been removed. If the complainant is dissatisfied with local complaints resolution, he must take his complaint to the Health Services Ombudsman. The Ombudsman cannot look at them all.¹⁰⁵ She will look for indications of service failure and individual injustice and take on only a small proportion of the complaints received. The Health Committee recommends a widening of the Ombudsman's remit so that the Ombudsman is not limited to investigating cases where there will be a 'worthwhile outcome'.¹⁰⁶ Despite numerous reforms, the complaints process remains the subject of intense criticism. Underlying these problems is a persistent lack of openness amongst doctors when things go wrong.

¹⁰¹ Health Committee *Sixth Report - Complaints and Litigation* (June 2011), para. 13

¹⁰² *Ibid*, para. 86

¹⁰³ *Ibid*, para. 87.

¹⁰⁴ *Ibid*, paras. 90, 91, 96.

¹⁰⁵ Note that the Health Committee, above note 101, para. 50 recommended: 'Many people see the role of the Ombudsman as a general appeals process for the complaints system, but the remit under the Health Service Commissioners Act is much narrower than that. The Committee is of the view that a complainant whose complaint is rejected by the service provider should be able to seek independent review. The legal and operational framework of the Ombudsman's office should be reviewed to make it effective for this wider purpose.'

¹⁰⁶ Health Committee, see note 101 above, para. 49.

– ‘*Making Amends*’ recommended that: ‘the process of compensation does not undermine the strength of the relationship between patient and healthcare professional’;¹⁰⁷

We have seen that the wider NHS Redress reforms go some way towards addressing the problems identified by the CMO, but that civil litigation cost reform alone offers only a partial solution. The clinical negligence system creates a vicious cycle whereby doctors fear openly admitting their errors which undermines those aspects of NHS Redress which aim to enhance correction and communication, which in turn causes some to turn to litigation.¹⁰⁸ In a transparent, patient-led, outcome-driven NHS, improving access to justice for meritorious cases, reducing defensiveness and enhancing openness and learning are priorities which have proven impossible to achieve without addressing the inadequacies of clinical negligence. Keren-Paz observes that ‘filing a suit against a physician, and even more so finding her liable, are likely to generate reputation loss, which is greater than the loss which might be generated by the underlying event.’¹⁰⁹ Furthermore, this produces an asymmetry insofar as it harms the doctor without any corresponding benefit to the claimant.¹¹⁰ The result is that doctors seek to settle, though this too involves some reputation loss, or fight the claim excessively and obstruct fact finding. In the next sections I examine three methods which might address some of these problems. None is perfect.

¹⁰⁷ *Making Amends*, see note 10 above, p. 13.

¹⁰⁸ M. Brazier and E. Cave, see note 26 above, at 9.12.

¹⁰⁹ T. Keren-Paz, “Liability Regimes, Reputation Loss and Defensive Medicine” (2010) 18(3) *Medical Law Review* 363, at p. 367.

¹¹⁰ *Ibid*, p. 385.

B. FILLING THE GAPS

1. SCOTTISH NO FAULT COMPENSATION REVIEW GROUP

Sir Ian Kennedy's report on the Bristol Infirmary debacle argued that the culture of defensiveness within the NHS will persist as long as healthcare providers fear the stigma of settlement and litigation under the clinical negligence regime. He recommended: 'an alternative system for compensating those patients who suffer harm arising out of treatment from the NHS'.¹¹¹

The term 'no fault' compensation has been used to cover a wide range of schemes, even those which rely on some element of fault. The independent charity, Action against Medical Accidents (AvMA) recommends what it refers to as the 'avoidability test'.¹¹² This is based on the CMO's recommendations in *Making Amends* that a 'broader definition of sub-standard care' than *Bolam* test should be adopted in the redress scheme.¹¹³ The avoidability test would provide for compensation in all cases except those where the result was unavoidable.

An alternative would be to reject the fault-based test for medical error as in New Zealand.¹¹⁴ In a 'mutual NHS' it is arguable that blame has no place. To replace medical negligence litigation, patients would be compensated for accidents (or even for ill-health), without the need to prove fault, through a central fund. The NHS

¹¹¹ *Learning from Bristol: the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984 -1995* CM 5207 (London: Department of Health, 2001), para. 119. Keren-Paz reiterates this sentiment: 'Since reputation loss is a major cause of defensive medicine prior to the accident and concealment tactics afterwards, a shift to strict liability is likely to reduce these problems. T. Keren-Paz, see note 109 above, p. 388.

¹¹² Action Against Medical Accidents, *A Fair Compensation Scheme*, accessible at http://www.avma.org.uk/pages/a_fair_compensation_scheme.html.

¹¹³ CMO, *Making Amends: A Consultation Paper Setting Out Proposals for Reforming the Approach to Clinical Negligence in the NHS* (London: Department of Health, 2003) at p. 19 and p. 120.

¹¹⁴ Injury Prevention, Rehabilitation and Compensation Amendment Act (No. 2) 2005; K. Oliphant, 'Beyond Misadventure: Compensation for Medical Injuries in New Zealand', (2007) 15(3) *Medical Law Review*, 357; K. Oliphant, 'Compensation, Ideology and Patient Safety in New Zealand's No Fault System' (2009) 3 *Opinio Juris in Comparatione* paper No 3.

already provides free treatment, but the fund would give additional ‘top-up’ compensation, though not necessarily the equivalent compensation the patient would have received had he successfully pursued medical negligence litigation. Empirical evidence suggests that openness and honesty regarding medical errors in New Zealand is high.¹¹⁵ No fault scheme have worked in countries with a comprehensive social security system and high national insurance contributions, such as the Nordic countries, arguably because the ‘top-up’ involved is relatively small and therefore costs are manageable.¹¹⁶

In Scotland, the No Fault Compensation Review Group chaired by Professor Sheila Mclean recommended that, in conjunction with improved social welfare provisions, the Scottish Government implement a no fault system similar to that which operates in Sweden.¹¹⁷ The Swedish scheme operates for medical accidents and patients retain a right to litigate where they fail in their no fault claim, and a right to apply under the scheme if their litigation fails. However, unlike the Swedish scheme, the proposed Scottish scheme would not be based on the ‘avoidability’ test, ‘but rather on a clear description of which injuries are not eligible for compensation under the no fault scheme’.¹¹⁸ The Review Group assert that the scheme might prove cost effective in Scotland. The Scottish Government will now further analyse the proposals. If implemented, England might reconsider whether such a scheme poses a viable alternative to tort based schemes.¹¹⁹ There would be much to

¹¹⁵ P. Davis, R. Lay-Yee, A. Scott, R. Briant, S. Schug, “Acknowledgement of “No Fault” Medical Injury: Review of Patients’ Hospital Records in New Zealand” (2003) 11(326) *British Medical Journal* 79.

¹¹⁶ R. Dingwall, “No Fault is No Panacea” (2003) 326 *British Medical Journal* 997.

¹¹⁷ The Scottish Government, *No Fault Compensation Review Group Report* (15 February 2011), recommendation 2, accessible at <http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/No-faultCompensation>.

¹¹⁸ *Ibid.*

¹¹⁹ See *Government Response to House of Commons Select Committee Report on Patient Safety* Cm 7709, (2009), p. 12.

recommend such an approach,¹²⁰ but England's size and the strains it would put on the NHS make this an unlikely option in the short to medium term.¹²¹ The Review Group recognised that a disadvantage of no fault schemes is 'potential lack of affordability, particularly in the context of large national populations'.¹²² In part for this reason, English no fault schemes for medical accidents were rejected in 1978,¹²³ 1990,¹²⁴ 2003¹²⁵ and most recently by the Health Committee in 2011. The Health Committee, chaired by former health secretary Stephen Dorrell, argued that a no-fault scheme would increase the costs of settling claims between 20 per cent and 80 per cent; that the volume of cases would rise; and that the necessity to fix the 'pot' due to strains on NHS resources would mean that severely injured people would be worse off.¹²⁶ This article emphasises potential policy directions and implications. I therefore restrict my coverage to tort based schemes whereby there is no right to compensation unless there is a breach of civil law.

2. THE NHS REDRESS ACT 2006

Lord Justice Jackson recommended that Regulations are implemented to set up a new redress scheme for England under the NHS Redress Act 2006. The scheme would be designed to act as an alternative to litigation. It would, at least for the first few years, relate only to claims relating to hospital services.¹²⁷ Applicants would

¹²⁰ See M. Brazier and E. Cave, see note 26 above, 9.14-9.20.

¹²¹ Though see Lord Neuberger, *Costs, Management, Proportionality and Insurance*, para. 26. Accessible at <http://www.judiciary.gov.uk>

¹²² *No Fault Compensation Review Group Report*. See note 117 above, p 26.

¹²³ *The Royal Commission on Civil Liability and Compensation for Personal Injury*, (Cmnd. 7054-1, 1978), paras. 1304-1371.

¹²⁴ Harriet Harman MP: Compensation for Medical Injury Bill 1990; Rosie Barnes MP NHS (Compensation) Bill 1991.

¹²⁵ CMO, *Making Amends*, see note 10 above, chapter 7, paras. 9-11; C. Vincent, "Compensation as a Duty of Care: The Case for 'No Fault'" (2003) 12 *Quality and Safety in Health Care* 240.

¹²⁶ Health Committee *Sixth Report - Complaints and Litigation* (June 2011), paras. 151-157.

¹²⁷ NHS Redress Act 2006, s. 1(6).

need to show a 'qualifying liability in tort' (in other words, personal injury or negligence),¹²⁸ and that they have not brought civil proceedings in court though they may later do so if they choose not to accept a settlement offered under the scheme.¹²⁹ There is no right to appeal, though the applicant might choose to register a complaint about their care or the scheme.¹³⁰ An aggrieved patient may claim under the scheme, or alternatively the process could be triggered by a healthcare provider or in the course of the investigation of a complaint.¹³¹ The scheme would provide for free legal advice¹³² and free reports from jointly instructed medical experts.¹³³ In addition to the offer of compensation, 'redress' encompasses the giving of an explanation; an apology; and a report on the 'action which has been, or will be, taken to prevent similar cases arising'.¹³⁴ It is a mechanism by which different forms of redress might be delivered.

The NHS Redress (Wales) Measure 2008 enabled Wales to develop a redress scheme which was introduced in the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011. Parts came into force in April 2011, and the remainder will come into force in October. An optional fast track scheme (the 'Speedy Resolution Scheme') for low value claims (between £5,000 and £15,000) was implemented in Wales in 2005.¹³⁵ In the short term at least, it will exist alongside the new redress scheme. The intention is to bring together a fragmented system¹³⁶ under which complaints, claims and the reporting of

¹²⁸ NHS Redress Act 2006, s. 1(4).

¹²⁹ NHS Redress Act 2006, s. 2(2).

¹³⁰ NHS Redress Act 2006, s. 14.

¹³¹ NHS Redress Act 2006, s. 5. Section 13 places relevant bodies under a duty of co-operation.

¹³² NHS Redress Act 2006, s. 8(1).

¹³³ NHS Redress Act 2006, s. 8(4).

¹³⁴ NHS Redress Act 2006, s. 3(2).

¹³⁵ See M. Rosser, "The Changing Face of Clinical Negligence in Wales" (2010) 3 *Journal of Personal Injury Law* 162, p. 169.

¹³⁶ National Audit Office, Auditor General for Wales, *Clinical Negligence in the NHS in Wales* (Cardiff: National Audit Office, 2001). Accessible at: <http://www.wales.nhs.uk/page.cfm?pid=735>.

incidents were previously handled separately and inconsistently. The aim is to respond to all 'concerns', including complaints, incidents and compensation claims in a consistent manner.¹³⁷ In terms of 'communication' and 'correction', where a concern is raised,¹³⁸ the responsible body will prepare a written response which will detail the investigation and potentially an apology; action taken or to be taken; reminder of the right to take the case to the Ombudsman; and an offer to discuss the report.¹³⁹ The responsible body will generally have 30 days from the notification of the concern to achieve this. During this time, regulation 25 will require the responsible body to consider whether there is a 'qualifying liability in tort'. If so, Part 6 will apply. Within a period of 12 months, the responsible body may offer compensation (within the £25,000 limit); or a contract for care and treatment; an apology; an explanation; and a report on action taken to prevent recurrence of the event. If the offer is accepted, the complainant waives the right to bring civil legal proceedings in respect of the issue. Regulation 31 requires the NHS Body to show how they will improve their services on the basis of the concerns raised.

It will not be administered independently. The Association of Personal Injury Lawyers has expressed concern that the NHS in Wales will be 'judge and jury' of its own blunders'.¹⁴⁰ The Welsh model will have significant workload implications for the Health Boards which are intended to administer the scheme. In terms of the coverage of the scheme, the Welsh scheme was originally to have a considerably wider remit than the previously proposed English equivalent, covering primary care as well as hospital based serviced. However objections resulted in a more limited

¹³⁷ National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, Regulation 2.

¹³⁸ *Ibid*, Regulation 12 states who can raise a concern.

¹³⁹ *Ibid*, Regulation 24.

¹⁴⁰ APIL, "Patients to be Sidelined as NHS Regulations 'Rushed' Through" 8 March 2011, accessible at http://files.apil.org.uk/pdf/press_releases/2118.pdf.

scheme which does not apply to GPs or independent providers when they are not NHS indemnified.

In England the Act was less well received. The Committee for Constitutional Affairs warned that the NHS Redress Bill was ill-thought out and called for a pilot scheme:

[T]he Government has ... not satisfied us that it has successfully engaged with practitioners (both medical and legal) to ensure that the scheme will work. It is not apparent how cost effective the scheme will be, and there has been no reliable evidence of the likely cost of claims which would not have been pursued if the scheme had not been set up.¹⁴¹

Nor were these issues resolved in the parliamentary process. The legislation is broadly framed, and the details of the scheme would be contained in secondary legislation. The resulting Act was much criticised for its limited scope. Farrell and Devaney¹⁴² feared that it would not constitute a just redress system, which they define as one which emphasises access to justice, the principles highlighted by the CMO in *Making Amends*, accountability and independence.¹⁴³ Farrell and Devaney point out:

Under the redress scheme, ... both fact- and fault-finding will be managed and controlled by the NHS, thus enabling it essentially to act as judge and jury of its own (negligent) mistakes. It is hardly a situation likely to engender patient

¹⁴¹ Constitutional Affairs Committee, see note 17 above, p. 3.

¹⁴² A.-M. Farrell, S. Devaney, see note 13 above.

¹⁴³ *Ibid*, p. 632.

confidence that the redress scheme is to be administered in a fair and impartial manner.¹⁴⁴

The merging of various ‘concerns’ proposed in the Welsh scheme would be considerably harder to achieve in the NHS in England due to its relative size and complexity. In any event, there are advantages to retaining some delineation between the processes surrounding incidents, complaints and claims, provided the various bodies communicate with each other and the applicant is clear as to which body he should direct his concern. One possible problem ensuing from merging the various systems may be that complainants expect compensation.

Farrell and Devaney list the various points of departure from the recommendations made in *Making Amends*.¹⁴⁵ There is no separate, no fault scheme for neurologically impaired babies (where claims are usually over the £20,000 threshold likely to be adopted if the scheme is implemented),¹⁴⁶ there is no ‘duty of candour’ to encourage openness;¹⁴⁷ information relating to adverse events will not be protected from disclosure in court; and the NHSLA rather than the independent body recommended by the CMO would run the scheme.¹⁴⁸ Perhaps the biggest drawback of the scheme is its cost. Fenn, Gray and Rickman estimated that the scheme would cost in the region of £42m per year.¹⁴⁹

The then Health Minister, Jane Kennedy said of the Bill in 2005, ‘The NHS Redress Bill means fairness for patients, not fees for lawyers. It is an important step

¹⁴⁴ A-M Farrell, S Devaney, *ibid*, p. 648. See also S. Hunjan, S. Fox, “Does the Proposed NHS Redress Scheme Make Sense?” (2007) 151 S.J. 13, 414; and P. Gooderham, “Special Treatment?” (2007) 157 N.L.J. 694.

¹⁴⁵ And see M. Brazier and E. Cave, *Medicine Patients and the Law* (Penguin: London, 2007), p. 238.

¹⁴⁶ *Making Amends*, see note 10 above, recommendation 2.

¹⁴⁷ *Making Amends*, *ibid*, recommendation 12.

¹⁴⁸ *Making Amends*, *ibid*, p 122. Note that the Government has commissioned an Industry Review which may recommend reform or replacement of the NHSLA.

¹⁴⁹ P. Fenn, A. Gray and N. Rickman, “The Economies of Clinical Negligence Reform in England” (2004) 114 *The Economic Journal* 289.

in preventing a US-style litigation culture.’¹⁵⁰ The emphasis of the CMO’s report is on balancing procedural and substantive justice. The NHS Redress Act, on the other hand, prioritises cutting costs. We now have an alternate means of avoiding the much talked-about but little proved compensation culture – Lord Justice Jackson’s civil cost reforms. Given this, it is perhaps unsurprising that initiation stalled.

3. EXTENDING THE RTA PI SCHEME

The Government may yet follow Lord Justice Jackson’s advice and implement an NHS Redress scheme. However, an alternative has been suggested: implement a voluntary fast track personal injury system for clinical negligence claims under the recently adopted Road Traffic Act PI scheme.¹⁵¹

The RTA PI scheme hails from a Ministry of Justice report in 2007 which recommended retention of the small claims limit of £1000, and a new low value claims process for personal injury claims up to £10,000.¹⁵² This was eventually taken forward for RTA PI claims only. Clinical negligence was excluded, partly because the NHS Redress Act 2006 would cover such claims, but also because clinical negligence is frequently more complex than most RTA claims.¹⁵³ The RTA PI scheme had teething problems relating to the on-line system, and has had little time to embed. Nevertheless, Lord Young argues for its extension to clinical negligence

¹⁵⁰ Editorial “NHS Error Victims Could Get £20,000” *The Telegraph* 13 October 2005.

¹⁵¹ See Civil Procedures (Amendment) Rules 2010/621.

¹⁵² Ministry of Justice, *Case Track Limits and the Claims Process for Personal Injury Claims* CP 8/07, 2007.

¹⁵³ Ministry of Justice, Response to the Consultation: *Case Track Limits and the Claims Process for Personal Injury Claims* CP(R) 08/07, paras. 18 (Re: NHS Redress Act) and 21-23 (Re: relative complexity of clinical negligence claims). This resulted in criticisms of a two-tier system: K. Dowel, “PI Lawyers Slate MoJ on Claims Reforms” *The Lawyer* 28 July 2008.

claims and a higher limit of £25,000.¹⁵⁴ A public consultation was launched in 2011.¹⁵⁵

The RTA PI scheme has three stages, each with fixed costs and deadlines.¹⁵⁶

- Stage 1 – the claimant solicitor completes the claim notification form and send it to the insurer who may admit/deny liability.
- Stage 2 – if liability is admitted, the claimant obtains a medical report and the process continues with offers and negotiation of a settlement to a strict timetable.
- Stage 3 – where the parties cannot agree a settlement an application is made to court for a quantum hearing.¹⁵⁷

We have seen that the NHS Redress scheme might be costly to implement and operate. Extension of the RTA PI Scheme would not involve primary legislation and Lord Young argues that the scheme poses advantages over the NHS Redress scheme in terms of costs:

Lower value claims (£1–£25,000) under the NHSLA's largest scheme have an average settlement time of just over six months, although around 4 per cent of cases received by the NHSLA go to court. Total legal costs incurred in connection with NHSLA clinical claims closed in 2009/10 amounted to £163.7 million. To my mind, the current system is too costly, and it takes far too long for some medical negligence cases to be resolved. Unfortunately, the

¹⁵⁴ APIL calls for the Government to address 'ongoing technical problems' before considering extension of the scheme: Press Release: *APIL Opposes Proposed Extension of Streamlined Claims Process*, 1 July 2011.

¹⁵⁵ *Solving Disputes in the County Courts*, see note 4 above,

¹⁵⁶ See <http://www.rtapiclaimsprocess.org.uk>.

¹⁵⁷ Ministry of Justice, *Quick and Simple Compensation Scheme for Road Traffic Accidents* accessible at <http://www.justice.gov.uk/news/newsrelease080310a.htm>.

adoption of the Jackson proposals will not in itself substantially shorten the process.¹⁵⁸

Application of the scheme to clinical negligence claims is likely to reduce delay, simplify the process and thereby reduce costs for low value uncontested claims. Where liability is admitted, damage to the defendant's reputation would be controlled, but where the facts are disputed, the option of proceeding to litigation remains. The scheme is user friendly and enables transfer of electronic data via a web-portal rather than the costly, slow and laborious paper-based methods traditionally used. It offers opportunity for communication and correction.

Lord Young was critical of the NHS Redress Act which, as we have seen, would have allowed a panel of experts (overseen by the NHSLA) rather than independent lawyers to determine the appropriate level of compensation, resulting in potential criticisms of impartiality or unfairness. Extension of the RTA PI Scheme might avoid these pitfalls.¹⁵⁹ If we return again to the CMO's criticism of the clinical negligence system in 2003,¹⁶⁰ it seems that Lord Young's scheme might address the complexity, unfairness and speed of low value clinical negligence claims, while Lord Justice Jackson's proposals address their cost. Like the NHS Redress scheme, it would be non adversarial, and therefore likely to enhance openness.

One difficulty is that the RTA PI scheme is designed to deal with relatively simple cases. Breach and causation are significantly harder to determine in clinical negligence and this can result in delay and make fixed costs unwieldy. The scheme's funding arrangements would have to change and the source of funding is unclear.

¹⁵⁸ *Common Sense, Common Safety*, see note 9 above, 22.

¹⁵⁹ *Ibid*, 23.

¹⁶⁰ *Making Amends*, see above note 10, p. 13.

The RTA PI scheme is currently funded by the insurance industry. The Government welcomed Lord Young's report, but Lord Young is no longer available to champion the proposals having resigned in November 2010 over a gaffe concerning the recession. Instead the NHSLA is setting up a pilot,¹⁶¹ likely to run from April 2012. However, the NHSLA covers only a proportion of the clinical negligence scheme. At best its success will provide impetus to extend the scheme more widely. The Government's consultation states that, if successful, the scheme might also be rolled out to capture claims against those not employed by a Trust, such as GPs and dentists,¹⁶² but there are significant variations between claims brought against NHS trusts and claims against individuals. The pilot would not be readily transferrable. The Medical Defence Union calls for caution.¹⁶³ They propose a lengthy trial period by the NHSLA before any scheme is rolled out and question whether individual doctors would receive protections equal to claimants. Would they share the right to opt out of the scheme? How would their reputation be protected given that mere involvement in a claim, no matter its outcome, can have negative connotations? Many clinical negligence cases settle on the basis that the risk of litigation is high, not on the basis of admission of guilt. Lord Justice Jackson was also cautious in his appraisal of the RTA PI scheme. He called for monitoring to ensure that costs do not spiral due to 'satellite litigation'¹⁶⁴ and avoidance behaviour. The aim is a simplified process but Lord Justice Jackson lamented the fact that lengthy and unwieldy rules now accompany the simplest category of litigation.¹⁶⁵ Lord Justice Jackson's report

¹⁶¹ *Solving Disputes in the County Courts*, see note 4 above, para. 82.

¹⁶² *Ibid*, para. 82.

¹⁶³ *Medical Defence Union Response to Ministry of Justice Consultation: Solving Disputes in the County Courts* (2011).

¹⁶⁴ Lord Justice Jackson, see note 8 above, p. xix.

¹⁶⁵ 'Over 80 pages of new material will be added to the rule book, in order to deal with the simplest category of litigation which exists, namely low value RTA claims where liability is admitted' *Ibid*, p. 225. Complexity ramps up the costs: 'I fear that collectively these procedures might possibly open up a new theatre for the costs war' *Ibid*.

was published before the RTA scheme as rolled out. He had another mechanism for dealing with clinical negligence at his fingertips – the NHS Redress Act – and it was this he recommended.

C. CONCLUSION

Clinical negligence is an integral part of NHS redress which in turn is high on the political agenda. The Government proposes wide scale reforms of civil litigation costs and administration and this article has assessed those proposals against the wider goals of NHS redress. The first part of this paper considered how far recent reforms satisfied the requirements of a just redress system put forward by the CMO in 2003. We have seen that reforms of the NHS since 2003 have addressed faults in the complaints system, professional regulation, institutional regulation and the duty of candour. Taken in conjunction with the proposed reforms of civil costs, do they address the faults in the redress system as perceived by the CMO? We have argued that significant gaps remain and that these will be exacerbated if the reform proposals of civil litigation costs and legal aid are accepted. A stumbling block is the adversarial clinical negligence system which limits the openness of doctors which in turn limits the effectiveness of measures designed to improve communication, correction and sanction. I have much sympathy for the calls for a move to no fault compensation but this paper seeks to address policy options and implications and a no fault scheme for England has been ruled out, largely on the basis of cost. Two fast track low value tort based schemes have been proposed which I considered in the second part of the paper.

The NHS Redress Scheme was much criticised. Whilst it would reduce the adversarial nature of low value claims, it would be run by the NHSLA and would not address the lack of openness amongst healthcare professionals when things go wrong. The previous Administration delayed its implementation but Lord Justice Jackson called for its resurrection.

Lord Young pointed out problems with the proposed scheme which he felt would still take too long to resolve claims. Others, we have seen, have argued that it focused too heavily on cost cutting and not enough on access to justice and impartiality. It did not satisfy the requirements of a just redress system recommended by the CMO. A new method of cost cutting - civil litigation cost and administrative reform - has been recommended by Lord Justice Jackson and has received Governmental support. Lord Young's proposed alternative fast track scheme low value clinical negligence based on an extension of the RTA PI scheme still reflects monetary goals (affordability and speed) over access to justice. In claims against NHS Trusts, ADR might enhance correction and communication and improve openness but we have seen that if it is extended to individual practitioners it might have the opposite effect. The CMO's recommendation that a fast track, tort based scheme should encourage practitioners to be open and honest, and ensure that 'the process of compensation does not undermine the strength of the relationship between patient and healthcare professional' depends on wider NHS redress reform – improvements in complaints, professional regulation, institutional regulation and the duty of candour.

The necessity to ensure that redress is 'joined-up' is receiving inadequate attention. In this time of austerity measures, the focus is naturally on cutting costs, but losing sight of adequate access to justice will itself prove costly. Advances made

in relation to the complaints process and professional regulation are limited by the adverse effects clinical negligence has on the doctor patient relationship. Where financial compensation is barred by virtue of limitations on legal aid and civil law reform, more pressure will be placed on the complaints system and professional regulation to deliver appropriate sanction, communication and correction. If Scotland adopt a no fault system and the redress scheme in Wales proves effective, the dichotomy in access to justice will be sorely felt. The CMO recommended a comprehensive package of reforms to effect a culture change in the NHS. The Government are steering an altogether steadier course, prioritising the reduction of costs to the NHS. A low value, fast track scheme would reduce costs but a failure to serve the interests of patients will result in a lack of confidence not merely in the process of restoration, but in other aspects of NHS redress.